

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, **Item 1** should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages **1** and **2** should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item **21** is marked or Item **18** shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. <i>79 30874</i>			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
<i>George W. Balloch</i>						<i>December 19, 1979</i>					<i>6:00AM</i>		
3. SEX <i>Male</i>			4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH <i>9 - 8 - 1908</i>	YEAR	6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i>		IF UNDER 1 YEAR MONTHS <i>YRS</i>		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Delaware</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i>						
10. CITY OR TOWN OF DEATH <i>Elkton</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital of Cecil Co</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Engineer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>						
13a. STATE <i>Delaware</i>			13b. COUNTY <i>New Castle</i>	13c. CITY OR TOWN <i>Newark</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>11 Keller Rd</i>						
14. FATHER'S NAME FIRST <i>John</i>			MIDDLE	LAST <i>Balloch</i>	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO/UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>135-10-4974</i>		17. INFORMANT <i>Reta W. Balloch</i>		ADDRESS <i>11 Keller Rd. Newark, Del</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (b), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
5715 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) <i>Uremia</i>													
} DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cirrhosis of the Liver</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>12/17/77</i> , 19 <i>77</i> , to <i>12/17/77</i> , 19 <i>77</i> , that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on <i>12/18/77</i> , 19 <i>77</i> , and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) did (did not) view the body after death.										22c. DATE SIGNED <i>12-19-79</i>			
22b. SIGNATURE <i>Orlando Najera</i>										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Orlando Najera M.D.</i>										22e. ADDRESS <i>Main Street- Elkton, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>			23b. DATE <i>12-19-79</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Silverbrook Crematory, Wilm.</i>		23d. LOCATION CITY OR TOWN <i>N.C.</i>		COUNTY		STATE		
24. FUNERAL DIRECTOR <i>William J. Harrick</i>			ADDRESS <i>Newark, Dela.</i>		25a. DATE RECD BY REGISTAR <i>DEC 20 1979</i>		25b. FILE NUMBER						

Robert Roosevelt

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL ALONG WITH FORM P.M. 3. RETAIN PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. 3. RETAIN PAGE 5 FOR YOUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30875			
1- FOR STATE REGISTRAR		1. DECEASED NAME TYPE OR PRINT) Barton ,			MIDDLE Virgie		LAST			2a. DATE KNOWN <input type="checkbox"/> MONTH DEATH ESTI. MATED <input type="checkbox"/> DAY YEAR	2b. HOUR 12 02 79 M		
3. SEX Female		4 RACE White		5 DATE OF BIRTH MONTH 09 DAY 25 YEAR 01		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN		8. IF UNDER 24 HRS. MONTHS 0 DAYS 0 HOURS 0 MIN		2c. DATE PRONONCED DEAD 12 02 79	2d. HOUR 9:10 A.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil							
10. CITY OR TOWN OF DEATH North East, Md		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) R.D. 1				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired				12b. KIND OF BUSINESS OR INDUSTRY Housewife			
13a. STATE Md.		13b. COUNTY Cecil		14. CITY OR TOWN North East		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.D. 1					
14. FATHER'S NAME FIRST George W. Bostic		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME Lou Elle Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-28-8315		17. INFORMANT Gladys V. Blakenship		ADDRESS Md. Charlestown							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF 410- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Hypertension</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>B. Singh</u>		TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER		DATE SIGNED 6/21/79									
EXAMINER'S NAME (TYPE OR PRINT) Anant B. Singh		ADDRESS UNION Hospital, Ellicott, MD 21221											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-5-79		23c. NAME OF CEMETERY OR CREMATORIAL North East Methodist		23d. LOCATION CITY OR TOWN North East		COUNTY Cecil		STATE Md.			
24. FUNERAL DIRECTOR NAME <u>Saul R. Crouch</u>		ADDRESS North East, Md.		25a. DATE REC'D. BY REGISTRAR DEC 4 1979		25b. REGISTRAR'S SIGNATURE <u>Henry McBrady</u>							
DHMH - 17 (VR A15 ME (5)) 30M 7/73													

For more information about the
U.S. Small Business Administration's

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

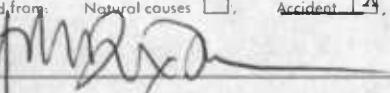
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH MONTH DAY YEAR			26 HOUR			
JOSEPH					BATTLE	December 5, 1979			12:53a_m			
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male		Black		Sept. 9 1928			51 yrs					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
North Carolina		USA					Cecil County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Perry Point		VA Medical Center Perry Point, Md.		Mechanic								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
District of Columbia				Washington		YES <input type="checkbox"/>		105 - 57th Street, S. E.				
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST		
Willie				Battle	Lucille					Bullock		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			Washington, D.C.		
YES		223 32 2422		Pearl M. Battle-Wife-105-57th St., S.E.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Heart Disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 1, 19 11, to December 5, 19 79 XXXXXXXXXX XXXXXXXXXXXXXX XXXXXX above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Eugene A. Jaeger M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/5/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene A. Jaeger, M.D.		22e. ADDRESS VAMC Perry Point, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/5/79		23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial Cemetery			23d. LOCATION CITY OR TOWN Suitland, MD		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Stewart Funeral Home, 4001 Benning Road, NE,					25a. DATE REC'D. BY REGISTRAR DEC 11 1979			25b. REGISTRAR'S SIGNATURE <i>John J. McCreary</i>				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 2 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. 3.0871					
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED		MONTH	DAY	YEAR	2b. HOUR	
		THOMAS			Lee		BEALE, II				<input checked="" type="checkbox"/>		12	29	1979	M	
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR 2d HOUR p M
male		white		June 10 1958		21						12 29 1979		12 29 1979		5:55 p M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Illinois		U.S.A.						Cecil County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Elkton		Union Hospital			Farm Hand			Farm									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
Maryland		Cecil		Rising Sun		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		332 Calvert Road									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		LAST									
Thomas		Lee		Beale		Doris		McGrady									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		ADDRESS											
No		229-70-4590		Thomas L. Beale		same as above											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic trauma												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
7 8122 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?												
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 5:40 M. 12-29-1979			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			Operator of motorcycle/auto collision.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET Rt. 273 E. 213			CITY OR TOWN		COUNTY Cecil		STATE Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE 												TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.												DATE SIGNED 12-30-79					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Hopewell Cemetery		23d. LOCATION CITY OR TOWN Port Deposit		COUNTY Cecil		STATE Maryland							
Burial		1-1-80															
24. FUNERAL DIRECTOR NAME Richard L. Goodie		ADDRESS Rising Sun, MD		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 2 1980													
BP _____																	
DHMH - 17 (VR A15 ME(5)) 15M 7/76																	

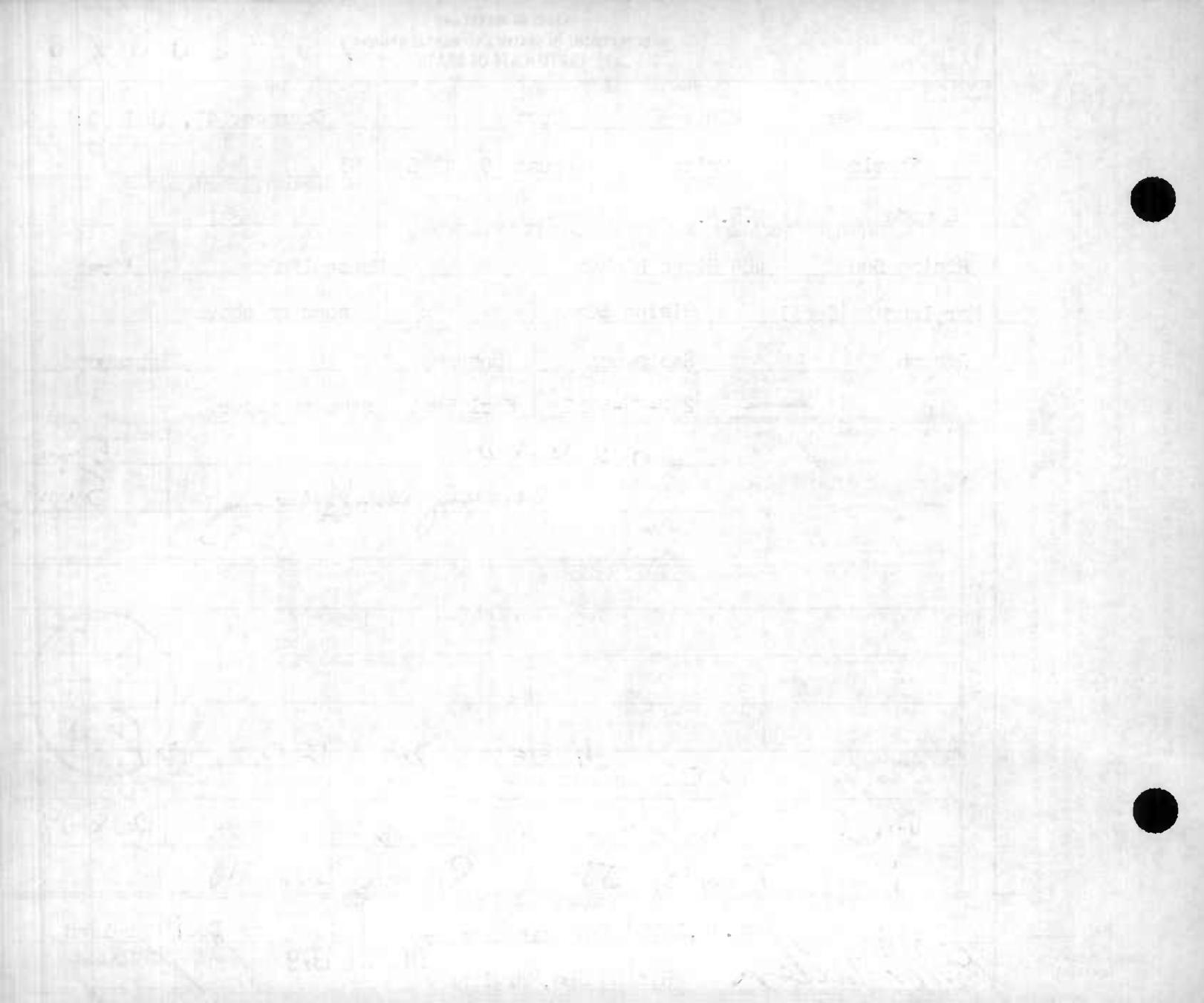
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IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 7930878							
1 - FOR STATE REGISTRAR	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR				
1 DECEASED NAME (TYPE OR PRINT)	Mary	Elsie	Best	December 17, 1979				3:20 AM				
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.			
Female	White	MONTH	DAY	YEAR	83							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8			9 BALTIMORE CITY OR COUNTY OF DEATH							
Canada	U.S.A.	MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Cecil MD.						
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
Rising Sun	404 Biggs Highway					Housewife			Retired			
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?			13e STREET ADDRESS						
Maryland	Cecil	Rising Sun	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	Same as above							
14 FATHER'S NAME	FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES)			16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
Joseph			Spotswood	Susanna			No			212-26-4752	Earl Best	same as above
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
411- Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost											5 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (b)											5 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-15, 1979, to 12-17, 1979, that (I) (we) last saw the deceased alive on 12-17, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE, Neil Taylor Jr	DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-18-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor Jr	22e ADDRESS Rising Sun, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 19, 1979	23c NAME OF CEMETERY OR CREMATORIAL Ebenezer Cemetery			23d. LOCATION CITY OR TOWN Rising Sun			COUNTY Sun City Maryland STATE				
24. FUNERAL DIRECTOR ADDRESS Rising Sun, Maryland												
25. DATE RECORDED DEC 20 1979 REGISTRAR SIGNATURE Larry H. Mulligan												



Item 11 g539 1/30/80 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30819

1- STATE REGISTRAR



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Willard</i>	MIDDLE	LAST <i>Biddle</i>	20. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	MONTH 12	DAY 27	YEAR 1979	2b. HOUR 11 1/2 AM	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH 9 YEAR 16	6. AGE (IN YEARS LAST BIRTHDAY) 29	IF UNDER 1 YR. MONTHS 50 YRS	IF UNDER 24 HRS. DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD 12 27 1979	2d. HOUR 12 1/2 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil County</i>			MD.	
10. CITY OR TOWN OF DEATH <i>Earleville</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Home-nr. Earleville</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Night watchman</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Cecil</i>	13c. CITY OR TOWN <i>Earleville</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS <i>Beach House dt 282</i>						
14. FATHER'S NAME FIRST <i>John</i>		MIDDLE	LAST <i>Biddle</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Angie</i>		MIDDLE	LAST <i>Biddle</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/> NO		16b. SOCIAL SECURITY NO. <i>215-30-0662</i>		17. INFORMANT <i>Elizabeth Whitlock; grave keeper Earleville</i>		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)								1 1/2 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Joe B. Miller Jr.</i>		TITLE (SPECIFY) M.D. <i>Deputy</i> MEDICAL EXAMINER								DATE SIGNED <i>1/27/79</i>
EXAMINER'S NAME (TYPE OR PRINT) <i>Joe B. Miller Jr.</i>		ADDRESS <i>Union Chapel of Cecil Co Md</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/31/79</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Johnstown Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Earleville, Cecil, Md.</i>		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME <i>Edward Fellows & Son, Millington, Md.</i>		ADDRESS <i>21651</i>		25a. DATE RECEIVED BY REGISTRAR <i>JAN 2 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Edward Fellows</i>				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7	9	3	0	8	8	0	
												REG. NO.							
1 - FOR STATE REGISTRAR				2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		Dec. 20, 1979		2:55 PM							
William M. Bishop																			
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		White		Jan. 31, 1911				68				YRS		MONTHS DAYS HOURS MIN					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH				MD.							
West Va.		U.S.						Cecil											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY			
Rising Sun				Calvert Manor Nursing Home								Coal Miner				Mining			
13a STATE Md.				13b COUNTY Cecil		13c CITY OR TOWN North East		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e STREET ADDRESS 2477 Theodore Rd.							
14. FATHER'S NAME FIRST David Bishop				MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST Taradine				MIDDLE		LAST Lester					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. 232-14-0221				17. INFORMANT Mrs. Janice Linzy, 2477 Theodore Rd., North				ADDRESS East, Md				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				Myocardial Infarction 3 days															
				(b) Arteriosclerotic cardiovascular disease 2 yrs															
19. DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED								20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-31, 1979, to 12-20, 1979, that (I) (we) last saw the deceased alive on 12-20, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Neil Taylor Jr				DEGREE MD								ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-20-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor Jr				22e. ADDRESS Rising Sun, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/22/79				23c. NAME OF CEMETERY OR CREMATORIAL Bay View Methodist Cemetery, Bay View, Maryland				23d. LOCATION CITY OR TOWN				COUNTY		STATE	
24. FUNERAL DIRECTOR NAME HICKS HOME for FUNERALS, ELKTON, MD.				ADDRESS								25a. DATE REC'D. BY REGISTRAR DEC 28 1979				25b. REGISTRAR'S SIGNATURE Lester McAdoo			

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Exhibit 1

analyse and to render a final opinion

101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 1930381							
1 - FOR STATE REGISTRAR				2a DATE OF DEATH MONTH DAY YEAR December 24, 1979								2b HOUR P.M.							
1 DECEASED NAME FIRST MIDDLE LAST WOODROW W. BURNSIDE				6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS								IF UNDER 1 YEAR MONTHS DAYS							
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 25, 1912				IF UNDER 24 HRS HOURS MIN											
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD											
10 CITY OR TOWN OF DEATH Elkton				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital								12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner				12b KIND OF BUSINESS OR INDUSTRY			
13a STATE Maryland				13b COUNTY Cecil		13c CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e STREET ADDRESS 272 Bouchelle Road							
14 FATHER'S NAME FIRST H. MIDDLE Lewis LAST Burnside				15 MOTHER'S MAIDEN NAME FIRST Ceba MIDDLE LAST Burnside															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO 235-09-2964				17 INFORMANT ADDRESS Mrs. C. Merle Burnside, North East, Md.											
18 CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Myocardial Infarction (c) Coronary Arteriosclerosis												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 12/24/79 1979, to 12/24/79 1979, that (I) (we) last saw the deceased alive on 12/24/79 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.												22b. DATE SIGNED 12/28/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Stavrakis, M.D.				22e. DEGREE M.D.								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/28/79				23c. NAME OF CEMETERY OR CREMATORIAL Brookview Cemetery				23d. LOCATION CITY OR TOWN Rising Sun, Maryland							
24. FUNERAL DIRECTOR NAME Donald S. Hicks HICKS HOME for FUNERALS, ELKTON, MD.				25a. DATE REC'D. BY REGISTRAR JAN 7 1980								25b. REGISTRAR'S SIGNATURE Donald S. Hicks							

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 0 8 8 2

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST JAMES	MIDDLE HENRY	LAST CARLISLE	2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 19, 1979	2b. HOUR 7:45 PM
3. SEX Male		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 24, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 72	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil		
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A. Medical Center				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Retired	
12b. STATE Wyoming		13a. COUNTY Laramie	13c. CITY OR TOWN Cheyenne	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Brogdon	
14. FATHER'S NAME William		MIDDLE H.	LAST Carlisle	15. MOTHER'S MAIDEN NAME Maude		MIDDLE 	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes		16b. SOCIAL SECURITY NO. 1931-39		17. INFORMANT V.A.M.C. Records, Perry Point, Maryland.		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized acute peritonitis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1519 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) Large perforation of gastric carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF (c) 							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY STATE
22a. I certify that (s) (he) (she) attended the deceased from May 17, 1979 to December 19, 1979 XXXXXXXXXXXX , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. R. GARCIA, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 12-19-79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. R. GARCIA, M.D.		22e. ADDRESS VAMC, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 22, 1979	23c. NAME OF CEMETERY OR CREMATORIAL Christ Church Cemetery Greenville,		23d. LOCATION CITY OR TOWN Greenville,	COUNTY Greenville, Md.	24. FUNERAL DIRECTOR Reed Lattimore
25a. DATE REC'D. BY REGISTRAR DEC 28 1979		25b. REGISTRAR'S SIGNATURE Reed Lattimore					
BP _____							
DHMH - 16 50M 7/77 (VR A 15(4))							

1. *Artemesia* 2. *Agave*

secondo giorno primo

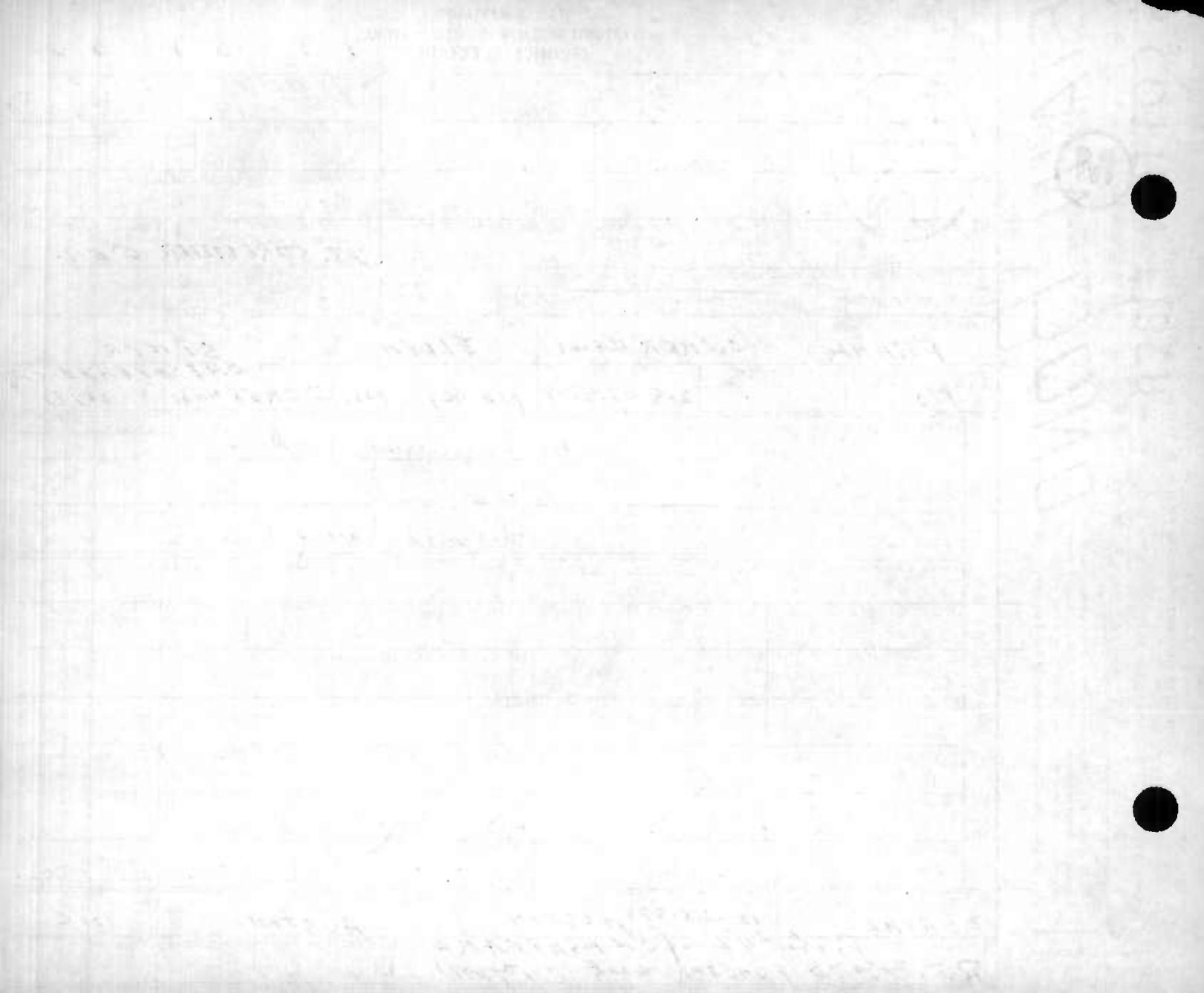
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____ of _____.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
			James M. Cockerham						Dec. 23, 79				10:15 M.
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.		
Male			Caucasian			Mar. 1, 1905			74				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil				
North Carolina U.S.									MD.				
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil Co.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. STORE KEEPER GEN.			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland			13b. COUNTY Cecil			13c. CITY OR TOWN Ches. City			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 143 North Street		
14. FATHER'S NAME FRANK			MIDDLE COCKERHAM LAST			15. MOTHER'S MAIDEN NAME ELLEN			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		SPICER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-07-8719			17. INFORMANT NANCY M. COCKERHAM MD			ADDRESS CHESAPEAKE CITY				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Advanced Lung Cancer</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/15</u> , 19 <u>79</u> , to <u>12/23</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Yogishchandra Patel</u>			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Yogishchandra Patel			22e. ADDRESS 179 W. Chestnut Hill Rd. Newark, Del.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-28-79			23c. NAME OF CEMETERY OR CREMATORIAL AUSTIN			23d. LOCATION CITY OR TOWN AUSTIN COUNTY STATE H.C.				
24. FUNERAL DIRECTOR NAME R.T. FOARD FUNERAL HOME CITY MD			25a. DATE REC'D. BY REGISTRAR DEC 31 1979			25b. REGISTRAR'S SIGNATURE <u>John J. Bradley</u>							
DHMH - 16 50M 1/76 (VR A 15 (4))													



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7930884		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Jane Louise Cornell						December 3, 1979						2:45 A M		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White		Month Day Year Feb. 20, 1914		65			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8		9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.				
Delaware			United States		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Cecil County			MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Elkton			Union Hospital of Cecil County		Floor Lady		Fireworks							
13a. STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2254 E. Old Phila. Road				
14. FATHER'S NAME First: John			Middle: Paris		15. MOTHER'S MAIDEN NAME First: Jane					Middle: Orr		Last:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS			Maryland				
No			213-05-6190		Mr. Philip W. Cornell, 2254 E. Old Pa. Rd., Elkton									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest due to Brain tumor</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cong. (R) kidney (congenital)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal failure.</u>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH microstate	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>12/2</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did) not view the body after death.			22b. SIGNATURE <u>Jur-Chih Hsu, M.D.</u>		22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 12/3/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 223 W. Main St., Elkton, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Dec. 6, 1979		23c. NAME OF CEMETERY OR CREMATORIAL Brookview Cemetery			23d. LOCATION CITY OR TOWN Rising Sun, Cecil, Maryland			COUNTY STATE			
24. FUNERAL DIRECTOR NAME			See Funeral Home, ADDRESS Elkton, Maryland		25a. DATE REC'D. BY REGISTRAR Dec. 6, 1979			25b. REGISTRAR'S SIGNATURE <u>John Deen</u>						

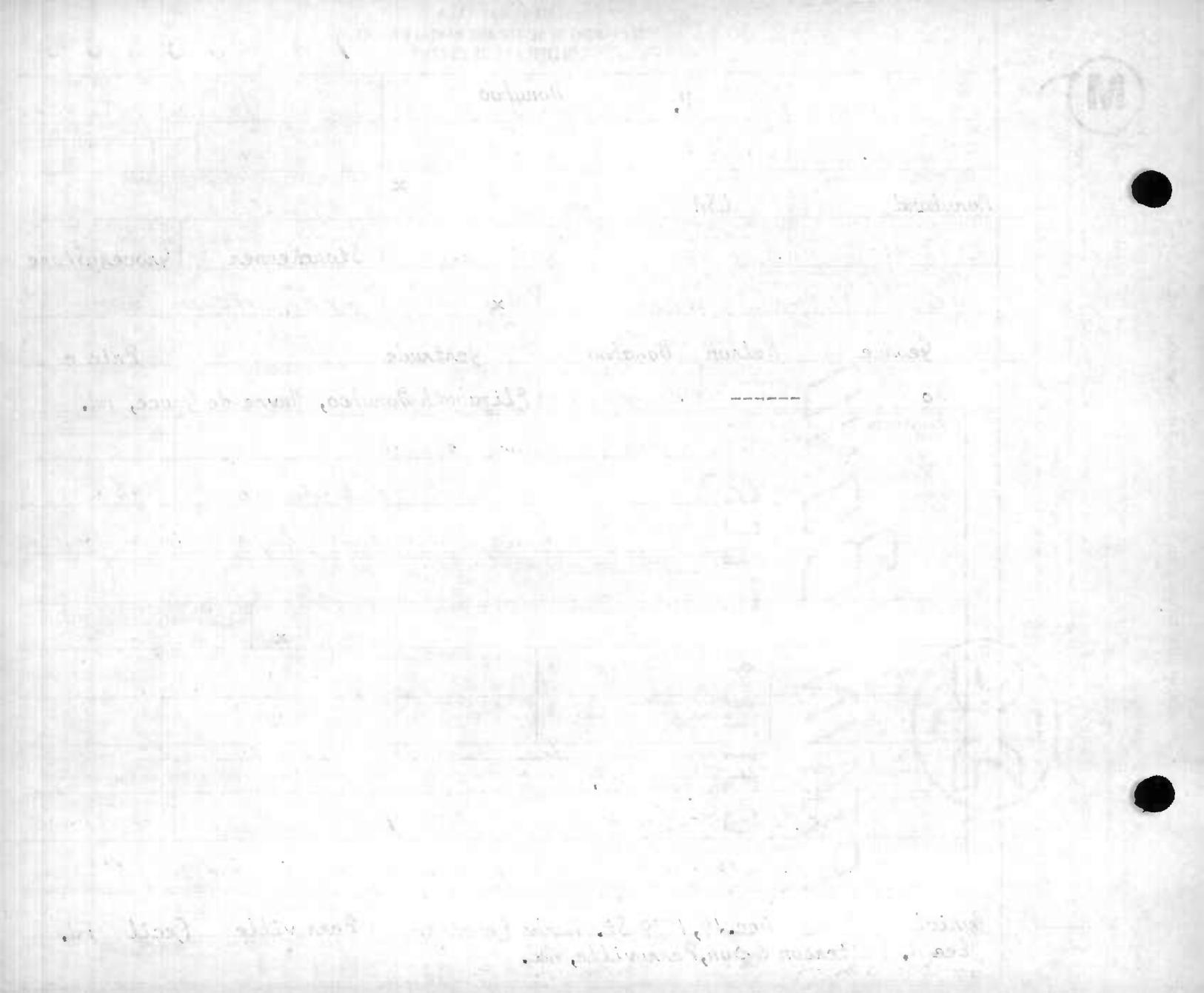
(Continued from back page)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
79 30885 REG. NO.													
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			CHARLOTTE V. Donahoo			Donahoo			12 16 79			6:05PM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female			White			1 11 1900			79 yrs				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland			USA						CECIL				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
ELKTON			DEVINE HAVEN CONV. HOME			Storekeeper			Grocery Store				
13a. STATE MD			13b. COUNTY CECIL			13c. CITY OR TOWN PERRYVILLE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS FRENCHTOWN ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
George Nelson Donahoo			Gertrude Price										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No			320-44-8571T			Elizabeth Donahoo, Havre de Grace, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>													
2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) <i>Cachexia, malnutrition due to OBS, Diabetes mellitus, Organic Brain Syndrome</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 19 27</i> , to <i>12-16 19 27</i> , that (I) (we) last saw the deceased alive on <i>11-30 19 27</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Hyung W. Oh, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>12-17-79</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Hyung W. Oh, M.D.</i>			22e. ADDRESS <i>123 w. High St. Elkton, Md. 21921</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Dec. 19, 1979</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Marks Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Perryville</i> COUNTY <i>Cecil</i> STATE <i>Md.</i>				
24. FUNERAL DIRECTOR <i>Jessie Patterson & Son, Perryville, Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>DEC 28 1979</i>			25b. REGISTRAR'S SIGNATURE <i>Hyung W. Oh</i>				



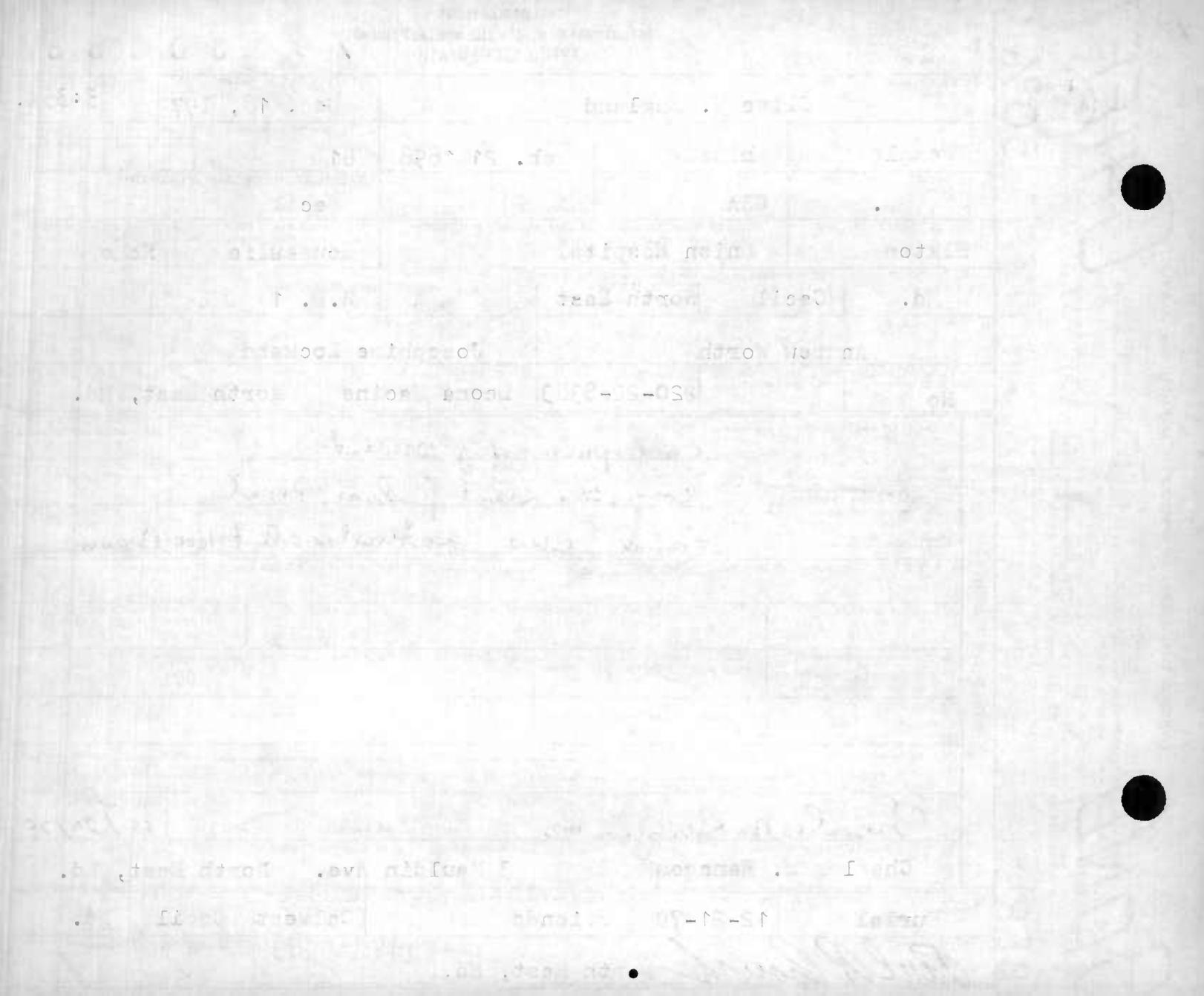
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

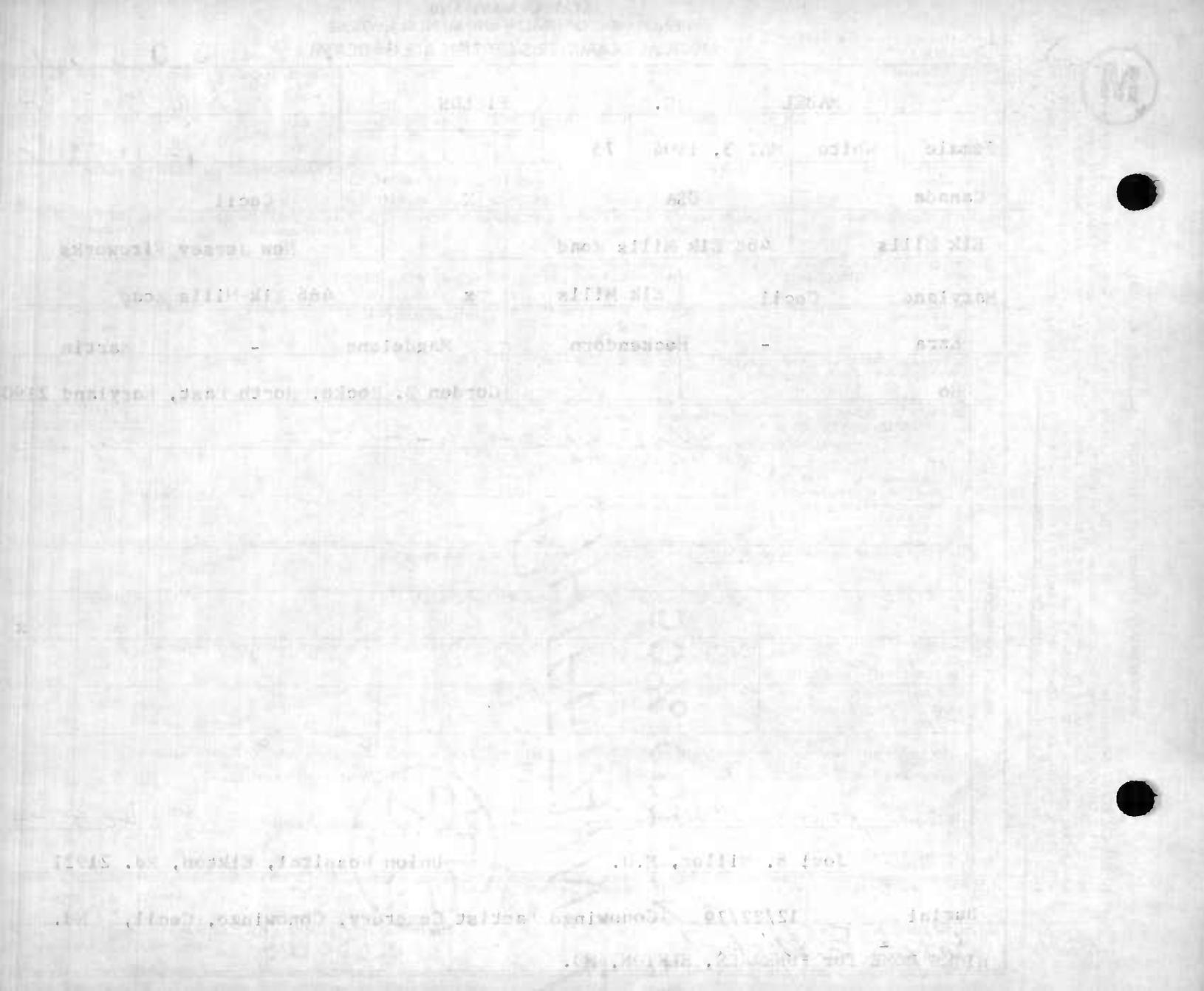
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7 9 3 0 8 8 6			
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Olive V. England						Dec. 18, 1979			5:35A.M.			
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE IN YEARS LAST BIRTHDAY		IF UNDER 1 YEAR		# UNDER 24 HRS				
Female		White		Feb. 21 1898			81		MONTHS DAYS		HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH								
Md.		USA					Cecil								
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Elkton		Union Hospital			Housewife			Home							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS						
Md.		Cecil		North East			R.D. 1								
14 FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		LAST						
Andrew Worth							Josephine Lockard								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No		220-22-8343			Leona Racine			North East, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Congestive pulmonary arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4140 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive heart failure, renal</i>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost (c) <i>Failure, C.V.R., arteriovenous shunt, left lung</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased olive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Charles M. Hensgen, MD</i>		DEGREE			ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/20/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles M. Hensgen		22e. ADDRESS 3 Mauldin Ave. North East, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-21-79			23c. NAME OF CEMETERY OR CREMATORIAL Friends			23d. LOCATION CITY OR TOWN Calvert County Cecil Md.		23e. DATE REC'D. BY REG. STAFF DEC 24 1979					
24. FUNERAL DIRECTOR <i>Paul R. French</i>		ADDRESS North East, Md.			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>										



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

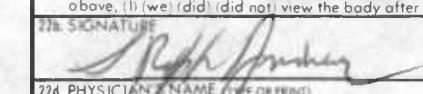
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30887				
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR			2b. HOUR				
			MABEL S. FIELDS						12 19 1979			? AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR			2d. HOUR	
Female		White		MAY 3, 1904		75 yrs.						12 19 1979			? PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil										
Canada		USA														
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
E1k Mills		466 Elk Mills Road										New Jersey Fireworks				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS								
Maryland		Cecil		Elk Mills		466 Elk Mills Road										
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
Ezra - Heckendorn		Magdelene - Martin														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS										
No				Gorden B. Rocke, North East, Maryland 2190												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) <i>Severe Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF 4280 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												'many' years				
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																
(c) _____																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?				
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. <i>Joel B. Miller</i>										MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS, Union Hospital, Elkton, Md. 21921										DATE SIGNED <i>Dec 9, 1979</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Burial			12/22/79			Conowingo Baptist Cemetery, Conowingo, Cecil, Md.										
24. FUNERAL DIRECTOR			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
<i>Hicks Home for Funerals, Elkton, MD.</i>						DEC 28 1979			<i>Joel B. Miller</i>							
BP																
DHMH - 17 (VR A15 ME (5)) 15M 7/77																



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.						
1 - FOR STATE REGISTRAR			2d. DATE OF DEATH MONTH DAY YEAR									2b. HOUR						
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Carolyn			Lewis		Fish			May 11, 1909			70			YRS				
3. SEX			4 RACE	White														
Female																		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Elkton, Md.			U.S.A.									Cecil						
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Elkton			Union Hospital									School Teacher			Education			
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS										
Md.			Cecil	Elkton				504 North Street										
14. FATHER'S NAME			FIRST	MIDDLE	LAST			15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
			Fred		Lewis			Emma			Emily	Elizabeth	Lewis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
no			212-38-4287			Emily E. Gray 8721 Geren Rd.			Silver Spring			Md.						
18 CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> about 30 min.																		
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																		
(b) <u>Coronary artery heart disease-</u> over 10 yrs.																		
(c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
<u>Diabetes</u>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
									<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 14, 1977</u> , to <u>Dec. 10, 1979</u> , that (I) (we) lost saw the deceased alive on <u>Dec. 9, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															22c. DATE SIGNED <u>12/11/79</u>			
22b. SIGNATURE  DEGREE <u>M.D.</u>															ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <u>S. Ralph Andrews, M.D.</u> 233 E. Main St., Elkton, Md 21921															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE					
Burial			12-14-79			Elkton Cemetery			Elkton			Cecil	Md.					
24. FUNERAL DIRECTOR NAME			SEE FUNERAL HOME ADDRESS			P.A.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
																		

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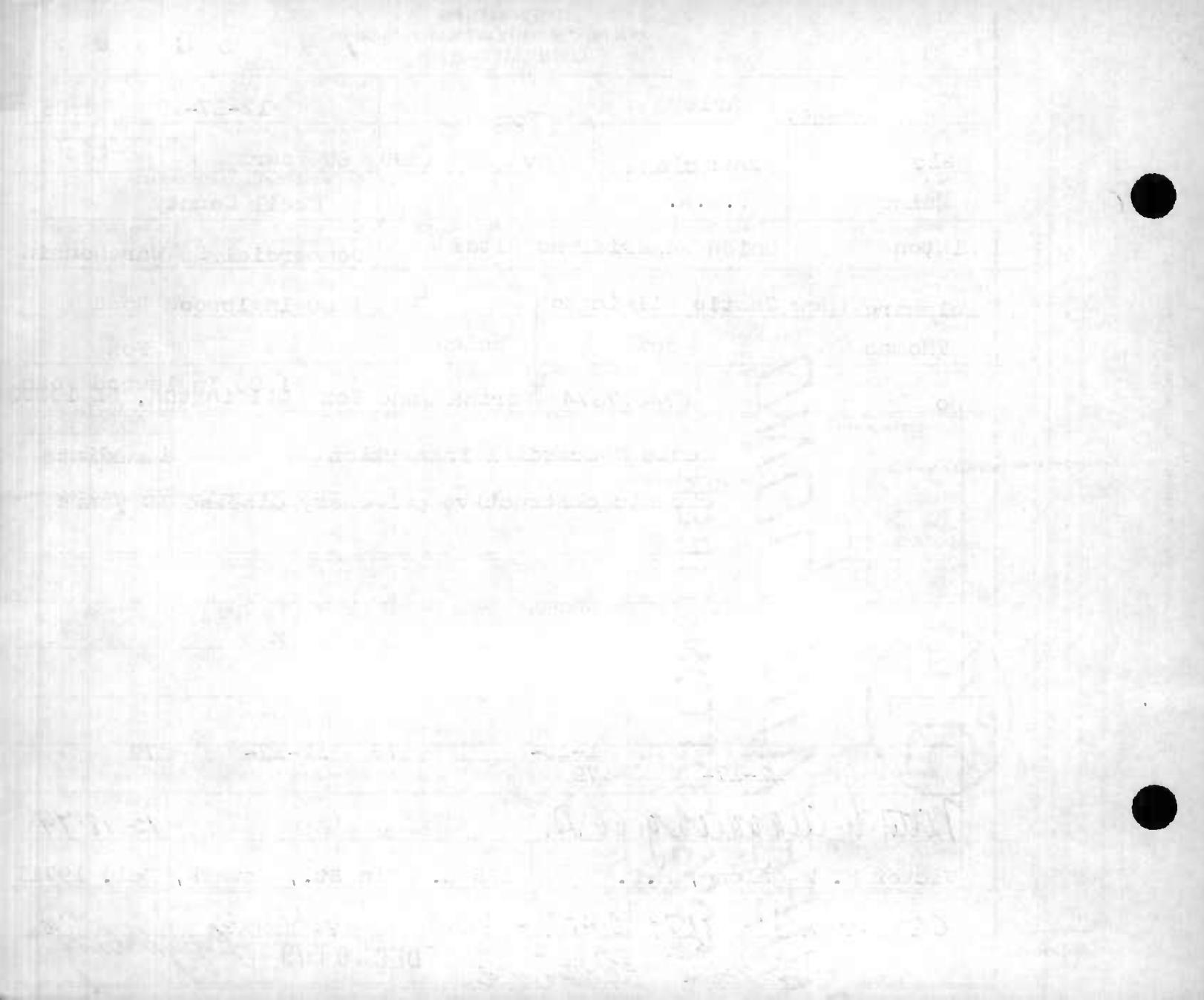
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7 9 3 0 8 8 9	
1 - STATE REGISTRAR			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			Arley			Fox						12-17-79 4:05 P.M.	
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	
Male			Caucasian			Nov 25 1899			80 years			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Cecil County	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.	
Elkton			Union Memorial Hospital			Commercial Sp			Warehousing				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
Delaware			New Castle			Wilmington						1800 Inglewood Road	
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME							
Thomas			Fox			Helen						LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			074077374			Bertha Jane Fox			1800 Inglewood Road			Wilmington, DE 19803	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 496- DUE TO, OR AS A CONSEQUENCE OF												immediate	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>chronic obstructive pulmonary disease 10 years</u> DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1-10-</u> 19 <u>73</u> , to <u>12-17-</u> 19 <u>79</u> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED	
<u>Victor M. Magalang, M.D.</u>												12-18-79	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS				
Victor M. Magalang, M.D.									325 E. Main St., Newark, Del. 19711				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			STATE	
Cremation			12/18/79			Cratin + Ferri's			West Chester			Pa.	
24. FUNERAL DIRECTOR NAME			ADDRESS			25. DATE REC'D BY REGISTRAR			25b. RECEIVED BY SPECIALIST				
Edward McLean			259 E. Main St.			DEC 20 1979			John Magalang				
Lee and Rose Elkton, Md.													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial/transit service. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7930890														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR														
Orie					FRINK	December 9, 1979						4:20 A.M.														
3 SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)															
MALE			BLACK		7 17 18			61	YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
N.C.			45								Cecil			Perry Point		VAMC, Perry Point, MD			Bus Driver			Md. of Ed.				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
Md.			Harford		Aberdeen						407 Dorsey St. Aberdeen, Md.			Irish			Mary			Singleton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												
yes			238 16 9315														IMMEDIATE CAUSE (a) Respiratory Failure									
1533			DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Sigmoid Colon with Metastasis																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			(c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE											
22a. I certify that (I) (this hospital) attended the deceased from Nov. 7, 1979, to December 9, 1979, that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not view the body after death, _____)																										
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED																	
Prem Lal MD														12-9-79												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			VA Medical Center, Perry Point MD																				
Prem Lal MD																										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-13-79			23c. NAME OF CEMETERY OR CREMATORIAL Hartford Mem. Gardens			23d. LOCATION CITY OR TOWN			COUNTY			STATE											
24. FUNERAL DIRECTOR NAME A. Beard Funeral Home			117 Cecil Ave ADDRESS North East, Md. 21901			25a. DATE REC'D. BY REGISTRAR DEC 11 1979			25b. REGISTRAR'S SIGNATURE Terry McCready																	

over & measured

10' 10"

10' 10"

On date 7/12/67

Site of 82

soil characteristics

Unconsolidated material, brownish tan, moistened

Depth

17' 10"

vol.

On date 7/12/67

10' 10"

soil type

soil profile

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		(GORCZINSKI) GOLDINSKI			12/6/79			8:50 AM				
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
Female			White		3/22/04		75			YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Poland			Poland							Cecil County Md			MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Elkton			Union Hospital									Housewife					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
Md			Cecil		North East					959 Irish Town Rd							
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST					
John					Kocello		Unknown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS										
No			----		Mr. Bronislaw Abramowicz, 149 Crumb Creek Dr		Woodlyn, Pa. 19094										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												Intra pericardial hemorrhage					
DUE TO, OR AS A CONSEQUENCE OF (b) Hemorrhage in myocardial infarction												hrs.					
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary thrombosis, Culmplex Art.												hrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Coronary arteriosclerosis																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED P.M.		21d. LOCATION STREET			CITY OR TOWN		COUNTY STATE					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f.												
22a. I certify that <input checked="" type="checkbox"/> (if this hospital) attended the deceased from <input checked="" type="checkbox"/> 12/13 1979 to <input checked="" type="checkbox"/> 12/7 1979, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <input checked="" type="checkbox"/> 12/7 1979, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) did <input checked="" type="checkbox"/> (did not) view the body over death.			22b. SIGNATURE Sheldon M. Glusman M.D			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/8/79								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 1412 Malvern Ave. Balt. Md. 21204														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 12/12/79		23c. NAME OF CEMETERY OR CREMATORIAL Our Lady of Czestochowa, Doylestown, Bucks, Penna.		23d. LOCATION CITY OR TOWN			COUNTY		STATE					
24. FUNERAL DIRECTOR NAME Ralph E. Hicks HICKS HOME FOR FUNERALS, EKTON, MD.			ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 13 1979			25b. REGISTRAR'S SIGNATURE Hector McBrady								

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Uvibreak

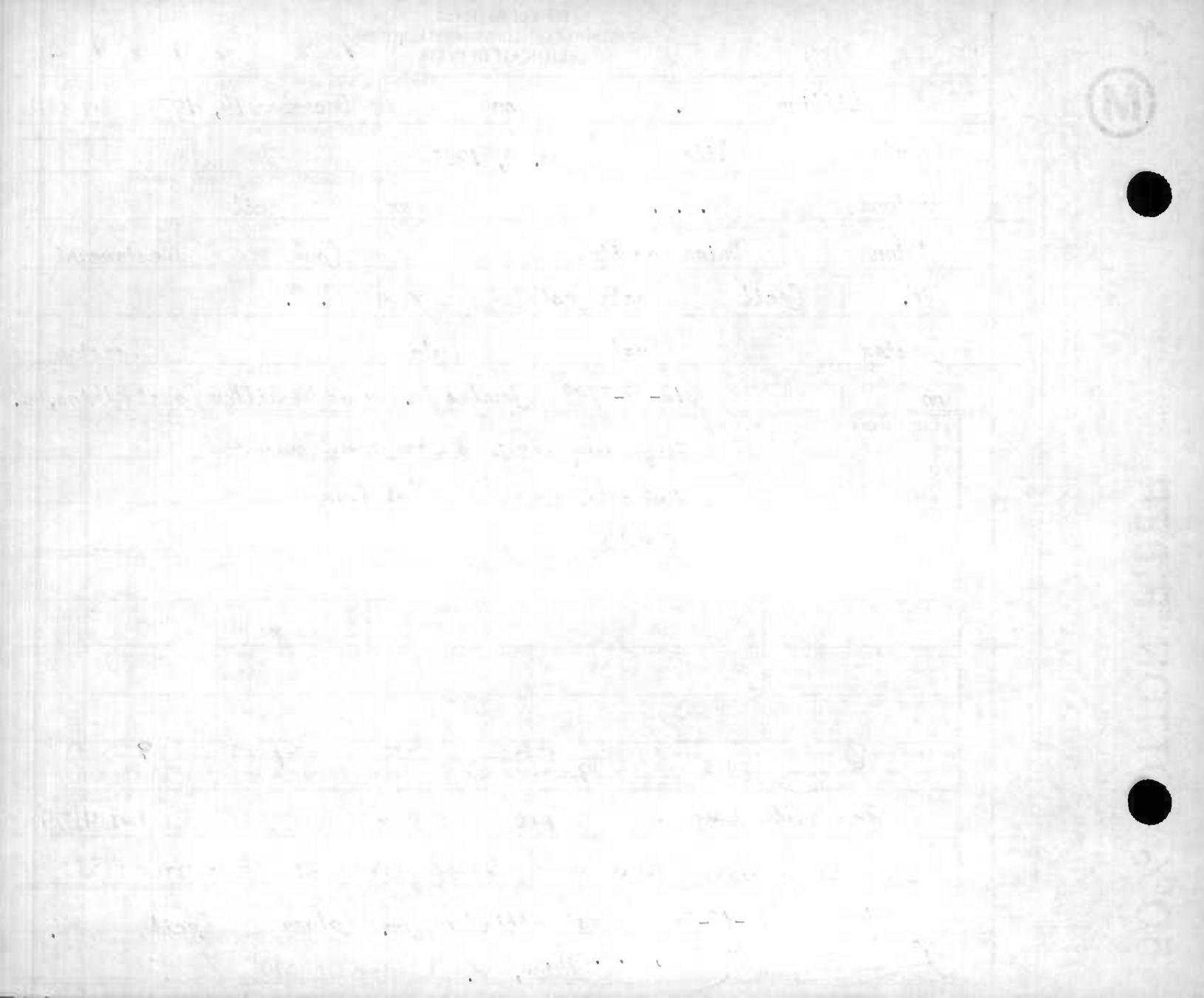
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 1930892											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR
Lillian			M.		Gray	December 14, 1979					1979
3. SEX			4. RACE		5. DATE OF BIRTH		2b. HOUR				
Female			White		Month Day Year Mar 9, 1925		IF UNDER 1 YEAR 54 yrs				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.				
Maryland			U.S.A.								
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Restaurant				
13a. STATE Md.			13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R. D.		
14. FATHER'S NAME Chester			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Lula						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 212-22-7736		17. INFORMANT Charles Wm. Hager 44 Willow Court Elkton, Md.		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest due to Brain metastasis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
1639 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Oat cell carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (c) COPD DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/26 1975 to 12/13 1979, that (I) (we) last saw the deceased alive on 5/13 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jui-Chih Hsu			DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12/14/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jui-Chih Hsu, MD			22e. ADDRESS 223 W. Main St., Elkton, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-17-79		23c. NAME OF CEMETERY OR CREMATORIAL West Nottingham Cem.			23d. LOCATION CITY OR TOWN Colona		COUNTY	STATE
24. FUNERAL DIRECTOR Name SEE FUNERAL HOME, P.A.			25a. DATE REC'D. BY REGISTRAR Dec 01 8 1979					25b. REGISTRAR'S SIGNATURE Loyalty DeBrady			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR
Mary S. Harman			December 12, 1979				2b. HOUR			
3 SEX female			4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 17, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE STATE OR FOREIGN COUNTRY Virginia			7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil			
10 CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil Co.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Practical Nurse			12b. KIND OF BUSINESS OR INDUSTRY Nursing
13a STATE Maryland			13b COUNTY Cecil		13c. CITY OR TOWN Elkton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 214 East Main St.	
14. FATHER'S NAME First Mason			Middle		Last Slade		15. MOTHER'S MAIDEN NAME First _____ Middle _____ Last Johnson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO 223-22-8986		17 INFORMANT Harold Harman Box 114 Aiken, South Carolina		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction										
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. } DUE TO, OR AS A CONSEQUENCE OF b) Coronary artery heart disease and hypertension over 10 yrs										
} DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (the physician) attended the deceased from Dec. 11, 1979, to Dec. 12, 1979, that (I) (we) lost saw the deceased alive on Dec. 11, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE <i>S. Ralph Andrews</i>			22c. DEGREE M. D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 12/12/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Ralph Andrews, M.D.			23. ADDRESS 235 E. Main St., Elkton, Md. 21921							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-16-79		23c. NAME OF CEMETERY OR CREMATORIAL Maple Hill Cemetery		23d. LOCATION CITY OR TOWN Bluefield, Tazewell, Va.			
24 FUNERAL DIRECTOR NAME <i>EE Funeral Home P.A.</i>			24b. ADDRESS Elkton, Md.		25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE <i>John W. Thompson</i>			

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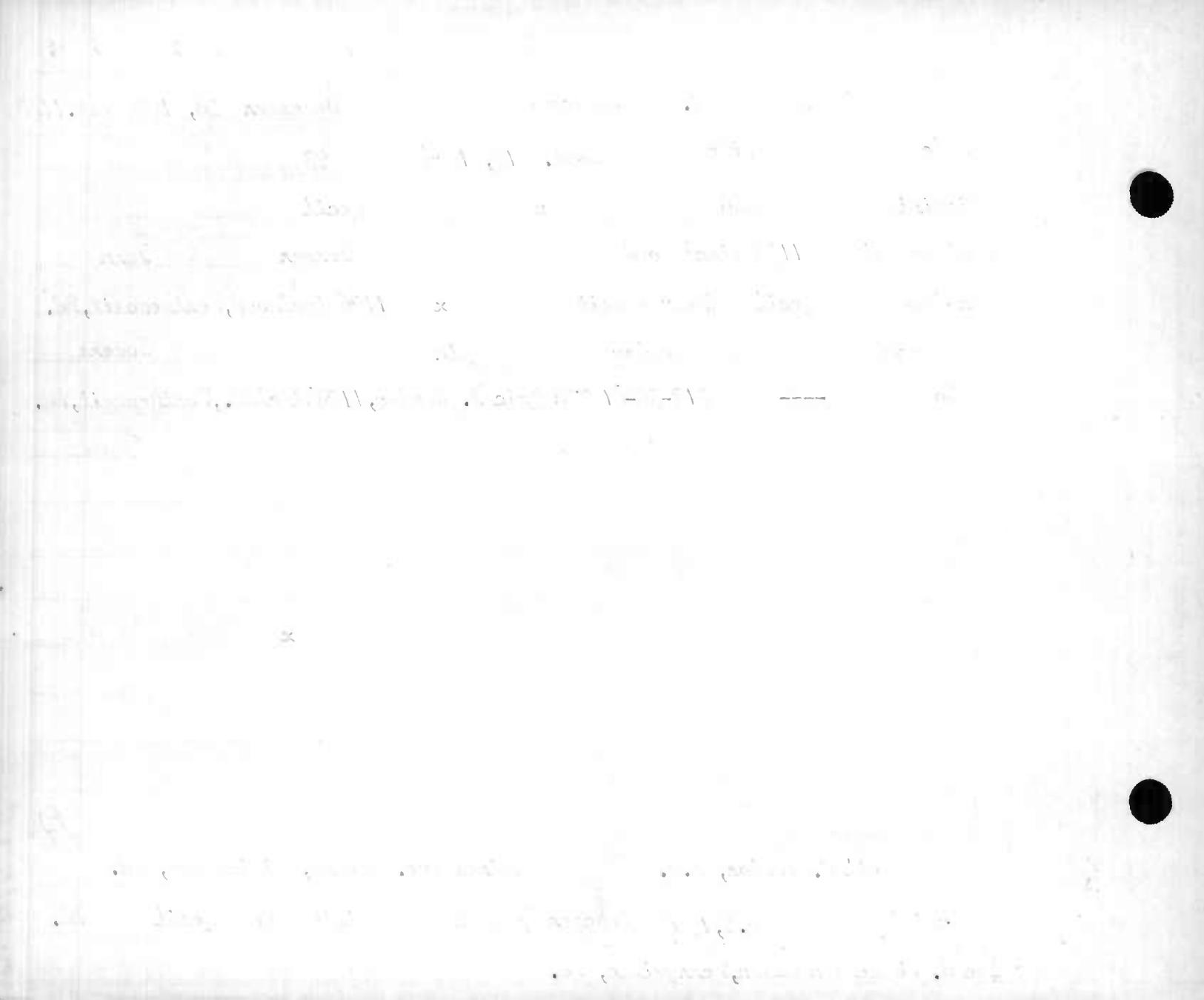
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
7 9 3 0 8 9 4 REG. NO.											
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR		
			James H. Hawley						December 28, 1979		
3. SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male			White			Sept. 14, 1886			93 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH		
Virginia			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Cecil		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Port Deposit			1136 Winch Road			Farmer			Farm		
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Cecil						1136 Winch Road, Port Deposit, Md.		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Jacob			Etta Sowers								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			213-36-8177A			Eric J. Hawley, 1136 Winch Rd., Port Deposit, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) A.S.C.R.D.											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs.											
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF											
{ DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1-5, 1974, to 12-28, 1978, that (I) (we) last saw the deceased alive on 1-28, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Neil Taylor			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-29-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil R. Taylor, M.D.			22e. ADDRESS Haines Ave. & Walnut, Rising Sun, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 2, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Ebenezer Cemetery			23d. LOCATION CITY OR TOWN Rising Sun COUNTY Cecil STATE Md.		
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.									25a. DATE REC'D. BY REGISTRAR JAN 1980		
									25b. REGISTRAR'S SIGNATURE Lee A. Patterson		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			ALLEN P. JOHNSON						December 18, 1979			10:05PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male			Negro			May 6, 1909			70			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
St. Va.			U. S. A.						Cecil County, MD			YRS.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Perry Point, Md.			VA Medical Center Perry Point, Md.			Nursing Assistant, F. A. Hosp.							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS	
Maryland			Harford			Harde Grace						730 Otsego Street	
14. FATHER'S NAME			MIDDLE LAST			15. MOTHER'S MAIDEN NAME						LAST	
Gold			Johnson			Odelia						Robinson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Yes			44 W 11			232 26 6063			Clarissa Garland, Harde Grace, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable Septicemia													
5990 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Urinary Tract Infection													
DUE TO, OR AS A CONSEQUENCE OF (c) Urinary Tract Infection													
DUE TO, OR AS A CONSEQUENCE OF (c) Urinary Tract Infection													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Metastatic Ca of Liver													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Jonathan Levi			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12-18-79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jonathan Levi, M.D.			22e. ADDRESS VAM CPerry Point, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 22, 1979			23c. NAME OF CEMETERY OR CREMATORIAL St. James United			23d. LOCATION CITY OR TOWN Harde Grace, Maryland			COUNTY STATE	
24. FUNERAL DIRECTOR NAME Odelia J. Bullock Bullock's Mortuary, Harde Grace, Md.									25a. DATE REC'D. BY REGISTRAR DEC 24 1979			25b. REGISTRAR'S SIGNATURE John J. Bullock	

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ANSWER TO THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit Permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	December 15, 1979			9:25P M			
Albert L Keneman Jr												
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			
MALE			White			MARCH 12 1916			63			
									IF UNDER 1 YR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
New Jersey			U.S.A.						Cecil Co.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Perry Point			VA Medical Center, Perry Point, Md			STORE MANAGER			Retail Sales			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Md			Balto			Towson			13e. STREET ADDRESS 942 Dulany Valley Rd.			
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			LAST			
Albert L Keneman Sr						Clara C. Corson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
yes WW II			155 10 6197			Florence Keneman			Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia 5990 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost DOUE TO, OR AS A CONSEQUENCE OF (b) Urinary tract infection DOUE TO, OR AS A CONSEQUENCE OF (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Alzheimer's disease												2 Days
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 19 76 to December 15 1979 Signature: Jonathan Levi, M.D. Address: VAMC, Perry Point, Maryland												22c. DATE SIGNED 12/16/79
22b. SIGNATURE Jonathan Levi			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			VAMC, Perry Point, Maryland						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY TOWN			
Removal			Dec 19 1979			Westview Crematory			Balto			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Evans Funeral Chapel, 8802 Harford Rd., Balto., Md.						DEC 19 1979			John McCreary			



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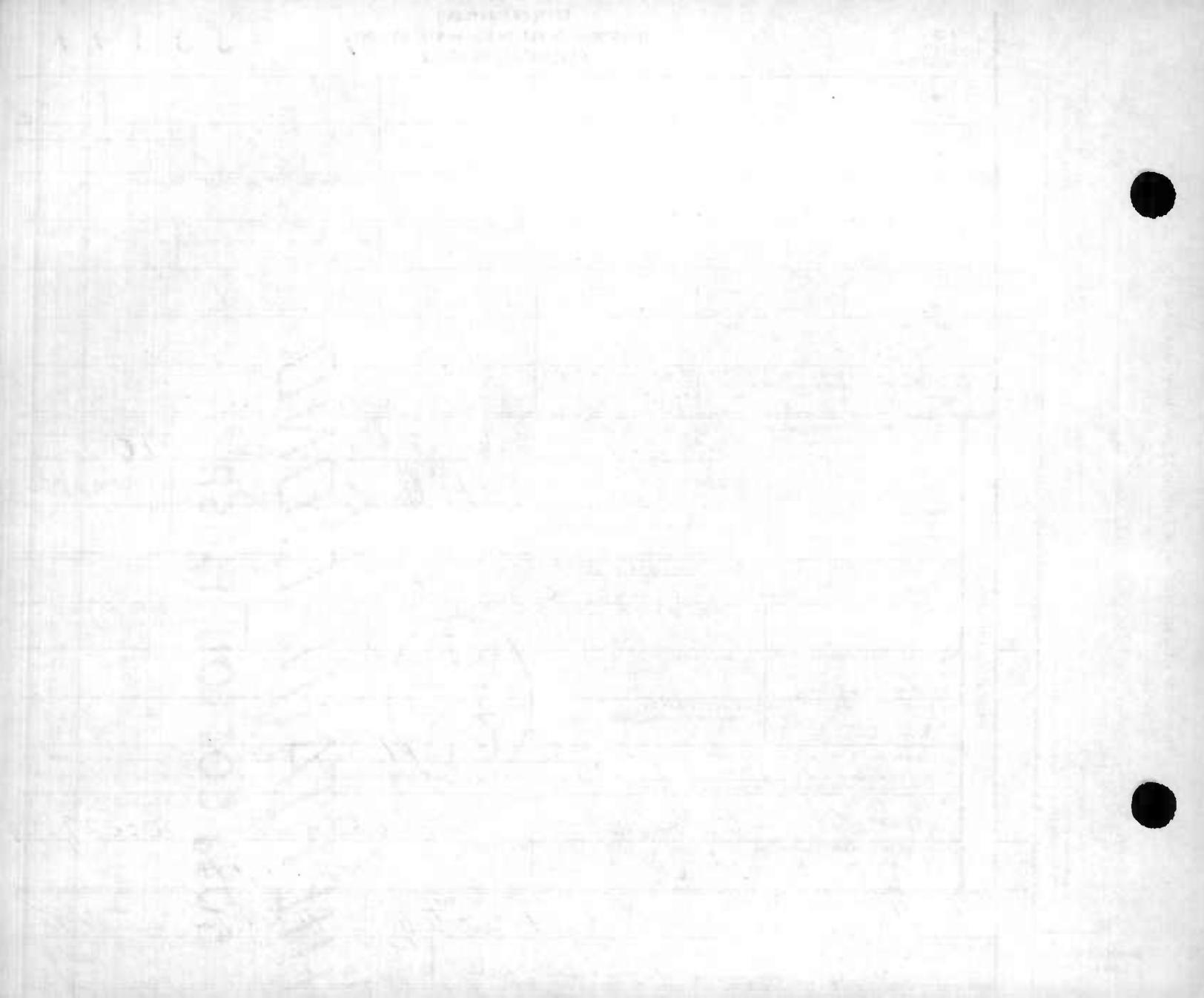
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7930897	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Louella M. Kent						Dec. 27, 1979						8:45A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		May 26, 1890			89			MONTHS	DAYS	HOURS	MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Cecil MD.			
Pennsylvania		U.S.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Rising Sun		Calvert Manor Nursing Home			Housewife								
13a. STATE Pa.		13b. COUNTY Chester		13c. CITY OR TOWN Oxford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 26 S. 5th St.				
14. FATHER'S NAME Lewis		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME EMMA LAURA Shae									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No 181-03-6847			17. INFORMANT Erma Fretz, 22 S. 5th St., Oxford, Pa. 19363			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hours					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 4293 { DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardio Vascular Disease</u> many years { DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>old rt hemiplegia, senility</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from Dec 29 1979 to present, 19, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE FAYE R. DOYLE MD		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED Dec 29, 1979					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FAYE R. DOYLE		22e. ADDRESS OXFORD, PA.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/29/1979		23c. NAME OF CEMETERY OR CREMATORIUM Oxford Cemetery			23d. LOCATION CITY OR TOWN Oxford, Pa.		COUNTY Chester Co.		STATE Pa.		
24. FUNERAL DIRECTOR NAME R. J. Foord's Funeral Home ADDRESS Ralph M. Reed, Rising Sun, Md.		25a. DATE REC'D. BY REGISTRAR JAN 1980			25b. REGISTRAR'S SIGNATURE John M. Murphy								



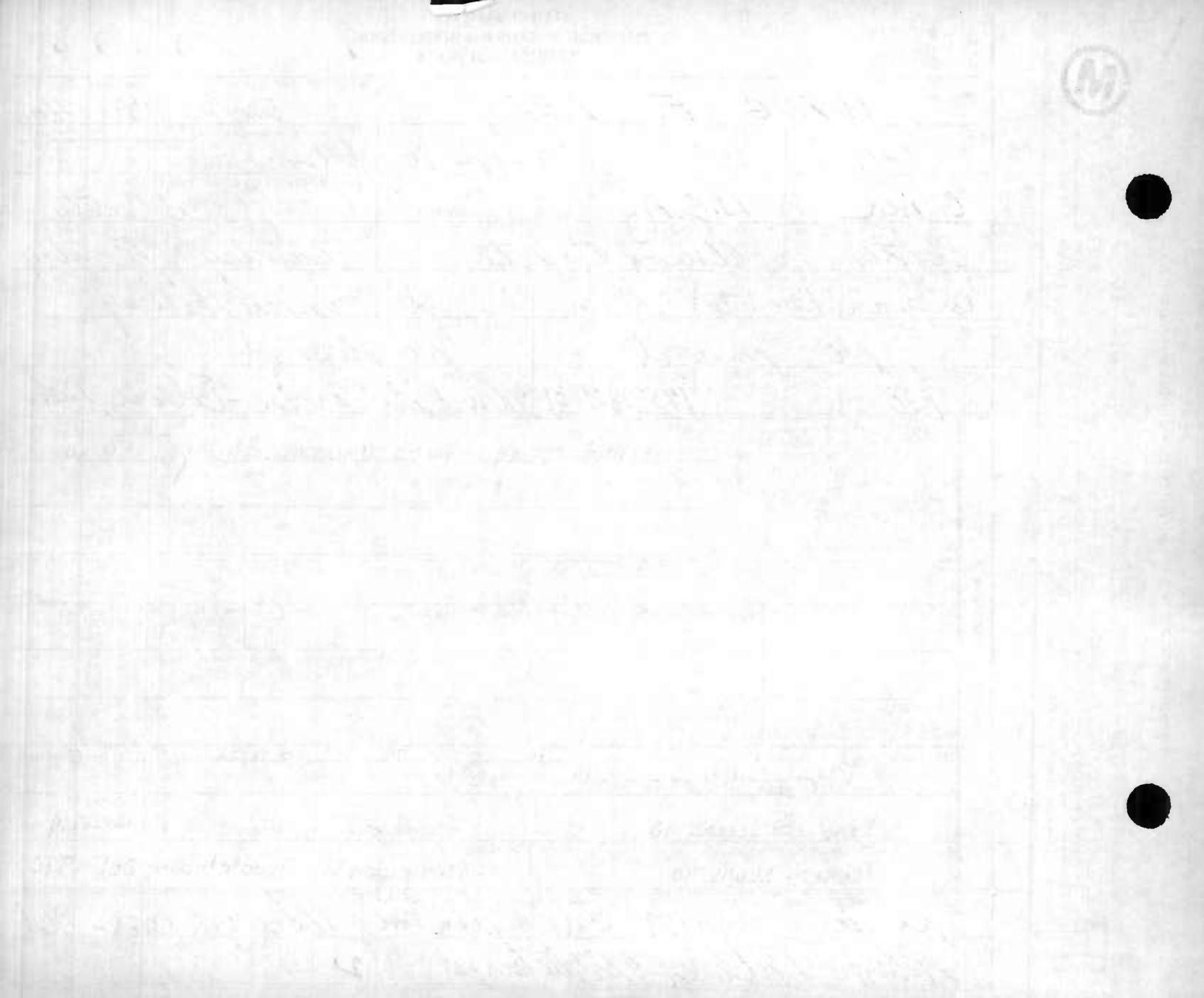
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST										
WING F. LEE						Dec 22, 1979				4:1 AM			
3. SEX Male			4. RACE W			5. DATE OF BIRTH MONTH 9 - DAY 19 - YEAR 10		6. AGE (IN YEARS LAST BIRTHDAY) 69 yrs			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE STATE OR FOREIGN China			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Ocic County MD.					
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A NURSING FACILITY, GIVE STREET ADDRESS) Wing Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laundry			12b. KIND OF BUSINESS OR INDUSTRY Laundry				
13a. STATE Delaware			13b. COUNTY New Castle			13c. CITY OR TOWN Odessa			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS DuPont Highway	
14. FATHER'S NAME No Record						15. MOTHER'S MAIDEN NAME No Record							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 175-28-4031			17. INFORMANT Mrs. Rita Carbone - Odessa, Del.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~6 mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic squamous carcinoma of lung													
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7/18, 19 79, to 4/22, 19 79, that (we) lost saw the deceased alive 12/21, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Kenneth Lewis, MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/26/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH LEWIS, MD			22e. ADDRESS 12 Pennington St, Middletown, Del 19709										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/24/79			23c. NAME OF CEMETERY OR CREMATORIUM Old Bohemia Cem.			23d. LOCATION CITY OR TOWN Warwick-Carl-Md			COUNTY STATE	
24. FUNERAL DIRECTOR NAME Robert C. Hutchison - Middleton, Del.			ADDRESS			25a. DATE REC'D. BY REGISTRAR JAN 2 1980			25b. REGISTRAR'S SIGNATURE John J. Murphy				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1930899 REG. NO.														
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	December 25, 1979			5:45A M					
Earle			Charles	Lescalleet										
3. SEX <i>Male</i>			4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>9-2-29</i> DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) <i>50</i>			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto. Md.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil County</i>			MD.				
10. CITY OR TOWN OF DEATH <i>Perry Point, Md.</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>VA Medical Center, Perry Point, Md.</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Gas Station Attendant</i>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <i>Md.</i>			13b. COUNTY	13c. CITY OR TOWN <i>Balto.</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>501 West Franklin Street</i>				
14. FATHER'S NAME FIRST <i>Carl E.</i> MIDDLE <i>Lescalleet</i> LAST			15. MOTHER'S MAIDEN NAME FIRST <i>Cora Kessler</i> MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. <i>9-30446-20</i>			17. INFORMANT <i>Mrs. Evelyn Barlow - 715 S. Montford Ave.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonitis</i> <i>1629</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
						DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of Lung</i>								
						DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
<i>Old Pulmonary Tuberculosis; Chronic Arachnoiditis with low pressure Hydrocephalus</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN					
22a. I certify that (I) (this hospital) attended the deceased from <i>December 22, 1978</i> , to <i>December 25, 1979</i> , <i>xxxxxx</i> , <i>xxxxxx</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated <i>xxxxxx</i> , above, (I) (we) (did) (did not) view the body after death									COUNTY STATE					
22b. SIGNATURE <i>Glen Dor. Rayson</i>			DEGREE						22c. DATE SIGNED <i>12-25-79</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GLENDO</i> RAYSON MD						ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12-28-79</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Balto. Md.</i>					
24. FUNERAL DIRECTOR NAME <i>John C Miller Corp Funeral Home, Baltimore MD</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <i>DEC 31 1979</i>			25b. REGISTRAR'S SIGNATURE <i>J. J. Brady</i>					

100 200 300 400 500 600 700 800

100 200 300 400 500 600 700 800

100 200 300 400 500 600 700 800

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100 200 300 400 500 600 700 800

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100 200 300 400 500 600 700 800

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7930900			
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
THOMAS			ROBERT			MACKIE			December 24, 1979			6:18 PM	
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR April 10, 1912			6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Montana			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil				
10. CITY OR TOWN OF DEATH Perryville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center Perry Point, Md			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Navy Officer			12b. KIND OF BUSINESS OR INDUSTRY Armed Forces				
13a. STATE Maryland			13b. COUNTY Montg.			13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 5014 Worthington Drive	
14. FATHER'S NAME FIRST Robert MIDDLE S. LAST Mackie						15. MOTHER'S MAIDEN NAME FIRST Helmi MIDDLE -- LAST Hankonen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II, Kor 579 52 9049			17. INFORMANT			ADDRESS				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) Pneumonia													
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Vascular Disease													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (he/she) attended the deceased from 16 March 1977 to 24 December 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I have (he/she) had full view of the body after death.													
22b. SIGNATURE <i>K.K. Leung MD</i>			22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED DEC 24 1979				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K.K. LEUNG, M.D.			22e. ADDRESS VAMC Perry Point, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/28/79			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crem.			23d. LOCATION CITY OR TOWN Suitland Maryland				
24. FUNERAL DIRECTOR NAME Gawlers Funeral Home			25a. ADDRESS 5130 Wis. Ave., NW Washington, D.C.			25b. DATE REC'D. BY REGISTRAR JAN 4 1980			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

be put into the box

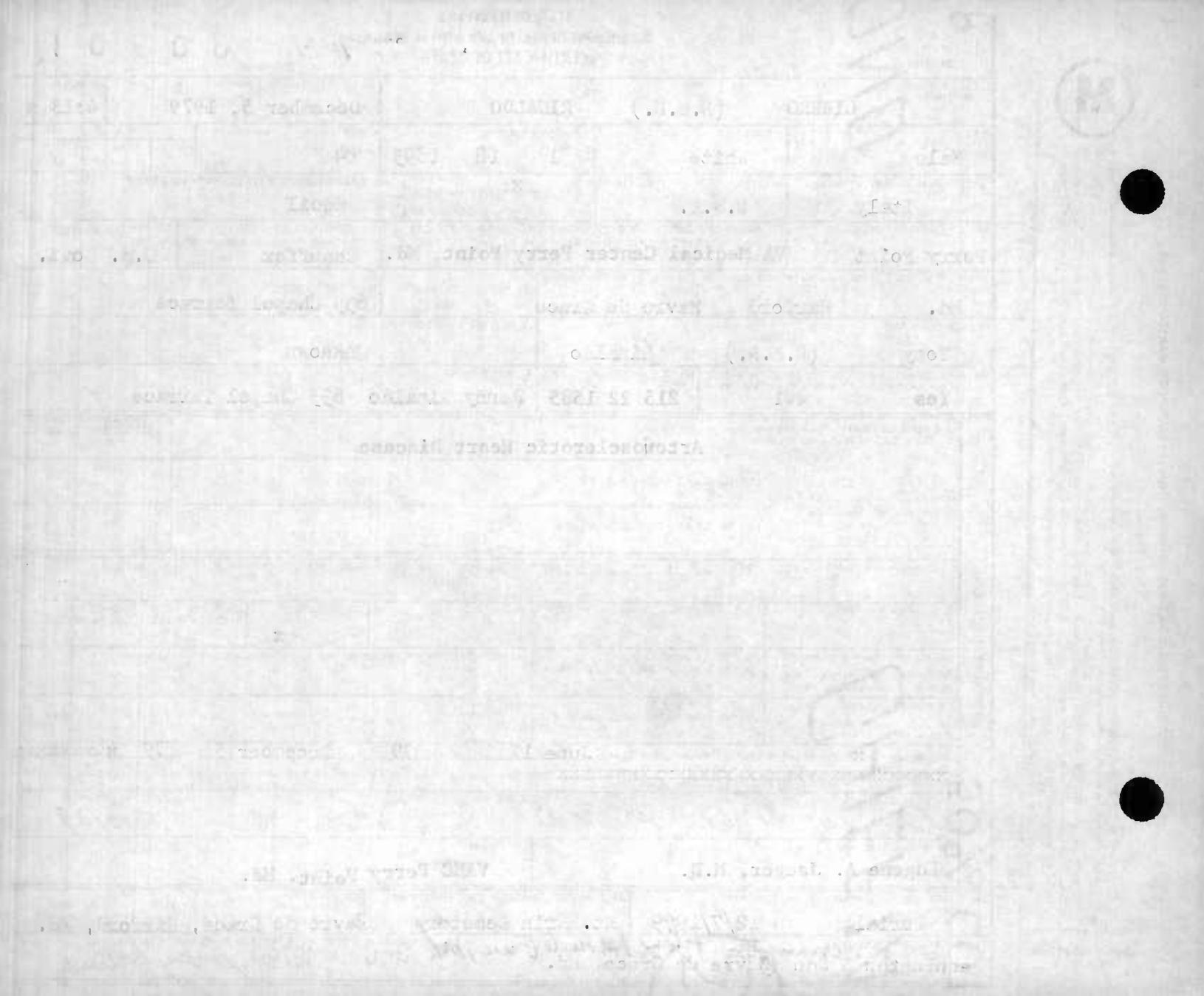
the box is

TO HOSPITAL OR ATTENDING PHYSICIAN: The
retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **Page 4**
REMOVED BY HOSPITAL OR ATTENDING PHYSICIAN.

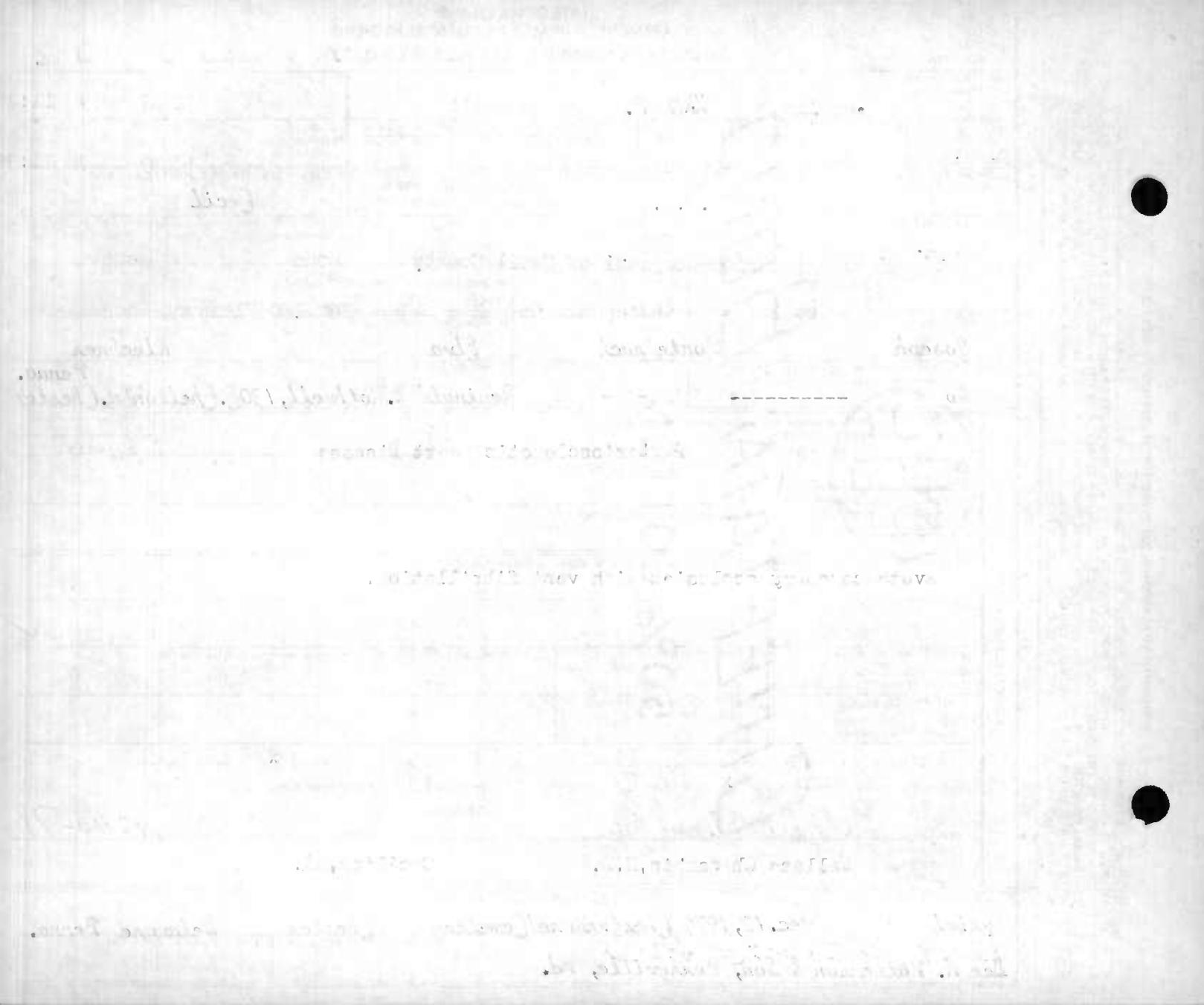
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILE.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30902					
1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH DAY YEAR		2b. HOUR	
		Rosella				XXX P.		Rothwell				<input type="checkbox"/> 12 7 19 79		11:36 AM			
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
Female		White		8. 2 10 07		72 yrs.						12 7 19 79		11:36 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. 72		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH		Cecil		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Elkton Md		Union Hospital of Cecil County				none				none							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Md.		Cecil		Chesapeake Ct		Box 180 Pleasure Shore											
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		LAST									
Joseph				Pontefract		Elva		Kleckner									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. ADDRESS		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
No		188-10-2793		Penns.		Reginald W. Rothwell, 130 E. Chelton Rd., Chester		3 years.									
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:																	
410- IMMEDIATE CAUSE (a) arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Acute coronary occlusion with vent fibrillation.																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)															
EXAMINER'S NAME (TYPE OR PRINT)		Wallace Ob nsahin, M.D.										MEDICAL EXAMINER					
23a. BURIAL, CREMATION, REMOVAL SPECIFY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION CITY OR TOWN		COUNTY STATE							
Burial		Dec. 12, 1979		Chester Rural Cemetery				Chester		Delaware Penns.							
24. FUNERAL DIRECTOR Lee A. Patterson & Son		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Lee A. Patterson & Son, Perryville, Md.				DEC 13 1979		Larry McAleney											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. The Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical statement must be completed at once.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
REG. NO. 7 9 3 0 9 0 3															
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH			DAY		YEAR		2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST												
Athal C Shriner													December 2, 1979 2:04 P M		
3 SEX Male			4 RACE White			5 DATE OF BIRTH MONTH December DAY 4, YEAR 1908			6. AGE (IN YEARS LAST BIRTHDAY) 70			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.						
10. CITY OR TOWN OF DEATH Perry Point			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center, Perry Point, Md.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland			13b. COUNTY Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS formerly of 1325 W. Fayette St.						
14. FATHER'S NAME FIRST Oliver MIDDLE Shriner LAST			15. MOTHER'S MAIDEN NAME FIRST Lila MIDDLE COX LAST												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. Disabled 212 05 3841			17. INFORMANT Mrs. Lila A. Sheppard			ADDRESS 131 Warwick Drive						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
5849 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Pulmonary Embolism															
DUE TO, OR AS A CONSEQUENCE OF (c) Acute Renal Failure															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus, Arteriosclerotic Heart Disease															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 10, 1979, to December 2, 1979 and that the deceased died on November 10, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated															
22b. SIGNATURE <i>Kam-ken Leung</i>			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN			22e. DATE SIGNED 12-2-79						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kam-Ken Leung			22e. ADDRESS VAMC, Perry Point, Maryland												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-5-1979			23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial			23d. LOCATION CITY OR TOWN Baltimore			COUNTY		STATE	
24. FUNERAL DIRECTOR RUCK & TOWSON Funeral Home, Inc. 1050 York Road Ruck Funeral Homes, Towson, MD. Towson, Md.			25a. DATE REC'D. BY REGISTRAR DEC 4 1979			25b. REGISTRAR'S SIGNATURE <i>Brody McBrady</i>									

DEATH CERTIFICATE The law requires that the death certificate be executed within 24 hours after death by a physician retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9.30904

1. DECEASED NAME (TYPE OR PRINT) William H. Smith			FIRST William H.	MIDDLE 	LAST Smith	2a. DATE OF DEATH December 19, 1979	MONTH DAY YEAR	2b. HOUR 3:20A M		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 01	DAY 22	YEAR 92	6. AGE (IN YEARS LAST BIRTHDAY) 87	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CECIL COUNTY MD.					
10. CITY OR TOWN OF DEATH Perry Point	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOILER OPERATOR	12b. KIND OF BUSINESS OR INDUSTRY INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA						13b. COUNTY GILES	13c. CITY OR TOWN NARROWS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS RT 1 BOX 3	
14. FATHER'S NAME FIRST WILLIAM			MIDDLE NMN	LAST SMITH	15. MOTHER'S MAIDEN NAME FIRST LAUSY	MIDDLE NMN	LAST THOMPSON	MD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WWI 225 14 8978			17. INFORMANT EMORY SMITH	ADDRESS 203EARLTON RD HAVRE DE GRANDE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pump failure --cardiogenic shock						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Acute inferior myocardial infarction (c) Atherosclerotic heart disease										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from XXXXXX-XXXXXX-XXXXXX-XXXXXX , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	October 23, 1979				22c. DATE SIGNED 12-19-79					
22b. SIGNATURE <i>Jonathan Levi</i>	DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JONATHAN LEVI, M.D.	22e. ADDRESS VAMC, Perry Point, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12-22-79	23c. NAME OF CEMETERY OR CREMATORIAL FAIRVIEW	23d. LOCATION CITY OR TOWN NARROWS GILES VA	COUNTY	STATE					
24. FUNERAL DIRECTOR NAME Pennington & Son, Havre de Grace, Md.	25a. DATE REC'D. BY REGISTRAR DEC 24 1979	25b. REGISTRAR'S SIGNATURE <i>Pennington & Son, Havre de Grace, Md.</i>								

27 MAY 1968

RECORDED

TIME 1700

WIND DIRECTION 180° WIND VELOCITY 10 MPH

TEMPERATURE 65°F HUMIDITY 65% RAINFALL 0.00 IN

SOIL MOISTURE - 50% GRASS
MATERIALS - LEAVES, SOIL, STICKS, ETC.
SPECIES - SISSEL'S CLOVER (TRIFOLIUM)

20 inches

0.5 cm diameter

SHRUB, SMALL VINES, LEAVES

0.1 CM DIAMETER

251.5

1000' above sea level on a north facing

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 30905 REG. NO.			
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)				MIDDLE		LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
			RAY C. SPENCER								DECEMBER 23, 1979				M
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS	
Male			White		NOV. 11, 1917			62			YEARS			MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10b. KIND OF BUSINESS OR INDUSTRY	
West Virginia			USA					WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Cecil			Miner Mining	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Elkton			225 E. Main Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Cecil		Elkton						225 E. Main Street				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
			James	G.	Spencer				Blanche		Williams				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.				17. INFORMANT			ADDRESS					
No			236-18-0723				Mrs. Lorraine L. Spencer, Elkton, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction died in sleep 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease over 2 yrs. (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Aug. 19 78 to Dec. 23 79, that (I) (we) last saw the deceased alive on Sept. 10 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Ralph Andrews</i> M.D.			22c. DEGREE						22d. DATE SIGNED 12/24/79						
22e. ADDRESS S. Ralph Andrews, M.D.			22f. ADDRESS 233 E. Main St., Elkton, Md. 21921												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 12/27/79			23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery			23d. LOCATION CITY OR TOWN Richwood, West Virginia			COUNTY STATE			
24. FUNERAL DIRECTOR NAME HICKS HOME for FUNERALS, ELKTON, MD.			25a. DATE REC'D. BY REGISTRAR DEC 28 1979						25b. REGISTRAR'S SIGNATURE <i>Patricia McCready</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3
rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
REG. NO. 9															
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Edward T. Thomas						December 19, 1979			12:30 A.M.			
3 SEX		# RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
Male		Caucasian		July 15, 1910			69			YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland		USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			Cecil							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Elkton		Union Hospital of Cecil Co						General Motors							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		Mill Creek Trailer Court 469 Fifth Ave.			
Delaware		New Castle		Wilmington											
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST			
Frank		H.		Thomas			Cora			Frances		Murphy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No		221-07-8048			Mrs. Virginia Blackburn, Newark, Del.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONIC PNEUMONIE</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>CHRONIC LUNG DISEASE</u> (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>SEVERE DENSIFICATION</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/17/79</u> , 19 <u>79</u> , to <u>12/19/79</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/18/79</u> , 19 <u>79</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.															
22b. SIGNATURE <u>J. Pollner, MD</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>12-19-79</u>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS												
Philip Pollner M.D.			131 W. Main - Elkton, Maryland												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>12/22/79</u>			23c. NAME OF CEMETERY OR CREMATORIAL Gracelawn Memorial Park, Wilmington, Delaware			23d. LOCATION CITY OR TOWN			COUNTY		STATE	
Burial															
24. FUNERAL DIRECTOR NAME <u>Donald S. Hicks</u>			ADDRESS <u>HICKS HOME for FUNERALS, ELKTON, MD.</u>			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>Robert McElroy</u>						

and the following

dates will be used:

X

VOLUME

PAGES

CROSSES

RECORDS

STANDS

100 seconds additional strip time

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printed - colorized - and folioed - numbered - PLATES - issued

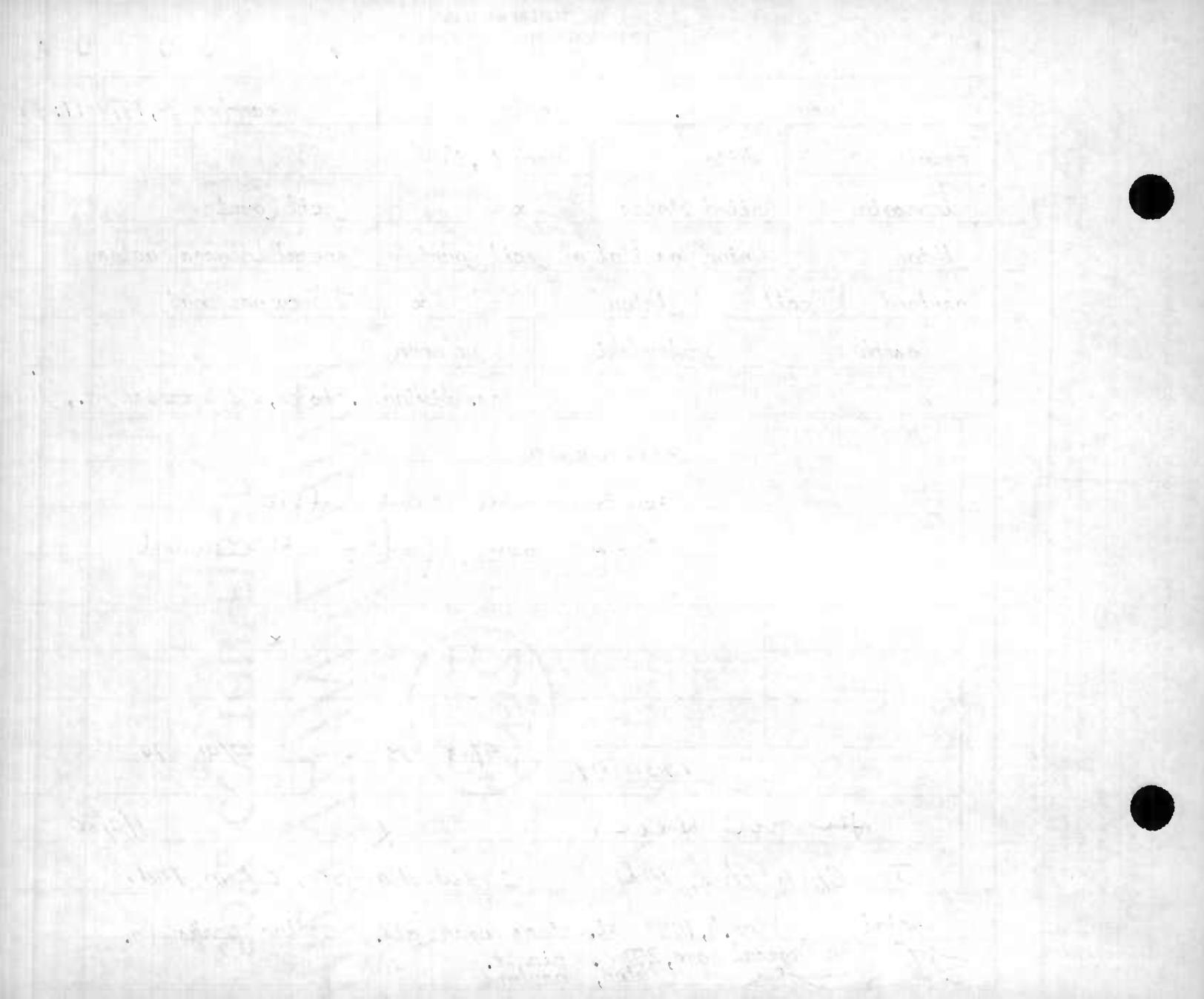
ON TOTAL NUMBER OF 1000 SHEET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Mary			M. Toole			December 29, 1979			11:30P			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female			White			March 17, 1899			80						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Minnesota			United States									Cecil County			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Elkton			Union Hospital of Cecil County			General Laborer			Factory						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Maryland			Cecil			Elkton						252 Sycamore Road			
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			LAST			
Joseph						Schlevnski			unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			AD.			
No									Mrs. Vivian M. Fisher, 252 Sycamore Rd., Elkto						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<u>4409</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) <u>gastric varices treat infect</u> DUE TO, OR AS A CONSEQUENCE OF															
(c) <u>Organic brain syndrome, ASD, gouty</u> DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/31 19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												<u>9/13 19 78</u> to <u>12/31 19 79</u>			
22b. SIGNATURE <u>Annie Hsu.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>1/12/80</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jui-Chih Hsu, MD.</u>			22e. ADDRESS <u>223 W. Main St., Elkton, Md.</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>Jan. 4, 1980</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>St. Peters Roman Cath</u>			23d. LOCATION CITY OR TOWN <u>Reading</u>			COUNTY STATE <u>Berks Pa.</u>			
24. FUNERAL DIRECTOR <u>See Funeral Home, 259 E. Main St., Elkton, Maryland</u>									25a. DATE REC'D. BY REGISTRAR <u>JAN 1980</u>			25b. REGISTRAR'S SIGNATURE <u>Holiday, McBrady</u>			

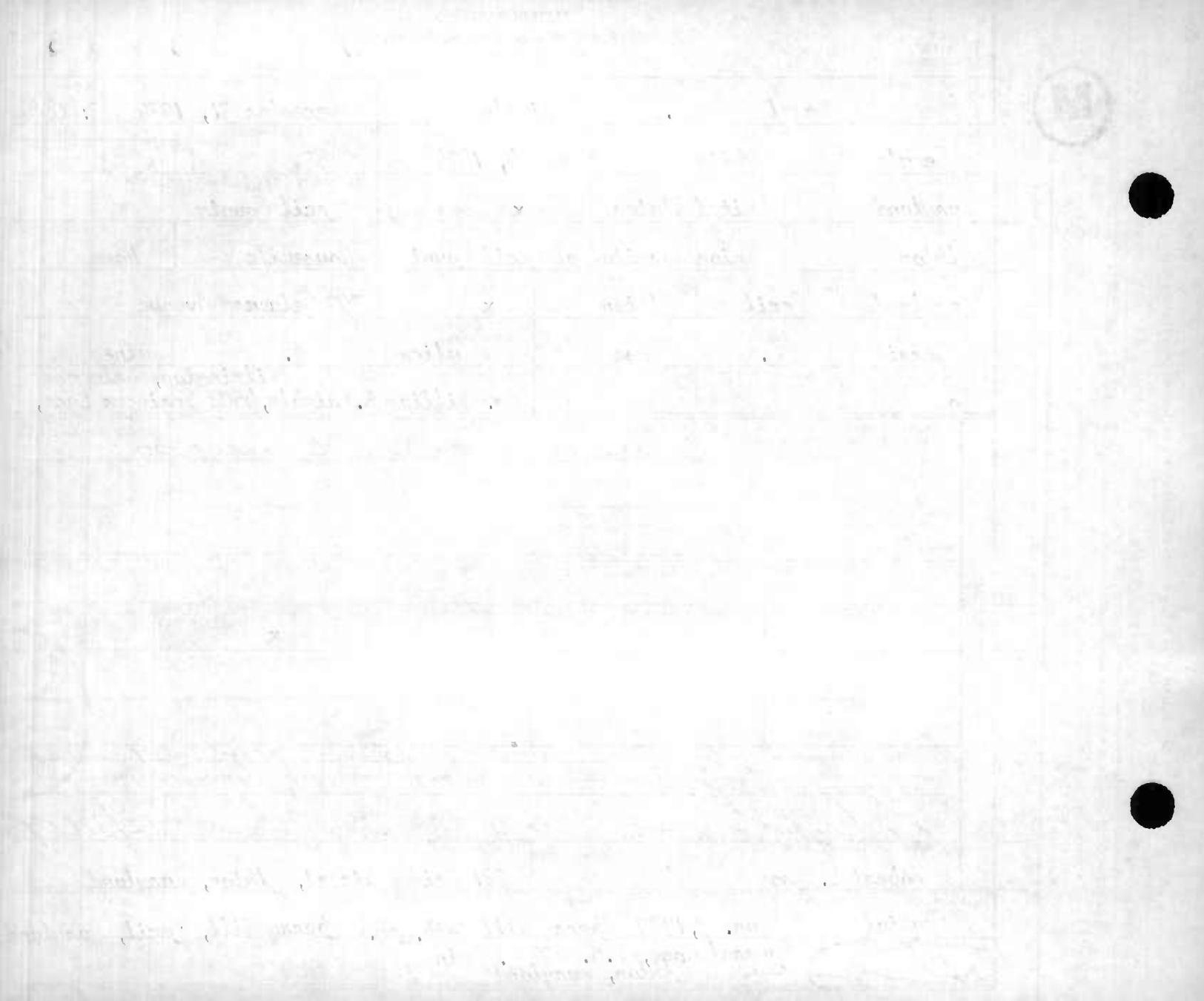


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.
1 - FOR STATE REGISTRAR			7 9 3 0 9 0 8							
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Hazel</i>	MIDDLE <i>M.</i>	LAST <i>Trimble</i>	2a. DATE OF DEATH MONTH <i>December</i>		DAY <i>31</i>	YEAR <i>1979</i>	2b. HOUR <i>3:00 A.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>May</i>		DAY <i>24</i>	YEAR <i>1894</i>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS <i>85</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil County</i>		MD.		
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital of Cecil County</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>				
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Cecil</i>	13c. CITY OR TOWN <i>Elkton</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>700 Delaware Avenue</i>				
14. FATHER'S NAME FIRST <i>Jessie</i>		MIDDLE <i>C.</i>	LAST <i>Rose</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Alice</i>		MIDDLE <i>M.</i>	LAST <i>Natney</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT <i>Mr. William R. Trimble, 4602 Springer Lane,</i>		ADDRESS <i>Wilmington, Delaware</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>410- Possable acute myocardial infarction</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first <i>410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first</i>										
(b) <i>410- Due to, or as a consequence of</i>										
(c) <i>410- Due to, or as a consequence of</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>11</i> 19 <i>75</i> to <i>9/18/79</i> , to <i>19 79</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>9/18/79</i> 19 <i>79</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. I (we) <input checked="" type="checkbox"/> did not view the body after death.										
22b. SIGNATURE <i>Robert L. Gray</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/31/79</i>				
THE PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert L. Gray</i>		22d. ADDRESS <i>721 Bridge Street, Elkton, Maryland</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Jan. 3, 1980</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cherry Hill Meth. Cem.</i>		23d. LOCATION CITY OR TOWN <i>Cherry Hill, Cecil, Maryland</i>		COUNTY STATE		
24. FUNERAL DIRECTOR NAME <i>See Funeral Home</i>		ADDRESS <i>P.O. Box 259, E. Main Elkton, Maryland</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 7 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Robert L. Gray</i>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR USE.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30909				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI. DEATH MATED		2b. HOUR		
Sadie B									Webb			<input checked="" type="checkbox"/> 12 24 79		60 M		
3. SEX	4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.	IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
F	White	9 8	81	98	YRS.				MONTHS	DAYS	HOURS	12 24	19 79		8:560 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH								
MD		USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			County Cecil								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Elkton, MD		Union Hospital of Cecil County						None								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE	13b. COUNTY	13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS								
MD	Cecil	Elkton, MD				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		194 Walnut Lane								
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME										
			James	P.	Rollison	Sadie						Burgess				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			Md.				
No			222-26-0040			Edith N. Webb			194 Walnut Lane, Elkton							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>												—				
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												DUE TO, OR AS A CONSEQUENCE OF				
(b) <i>—</i>												DUE TO, OR AS A CONSEQUENCE OF				
(c) <i>—</i>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
<i>several recent strokes</i>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?				
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <i>Henry Farkas,</i>			TITLE (SPECIFY) M.D. <i>Asstt Dep't</i> , MEDICAL EXAMINER									DATE SIGNED <i>12/24/79</i>				
EXAMINER'S NAME (TYPE OR PRINT) <i>Henry Farkas, MD</i>			ADDRESS <i>Union Hospital, Elkton, Md. 21921</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/27/79			23c. NAME OF CEMETERY OR CREMATORIUM Stillpond Cem.			23d. LOCATION CITY OR TOWN Stillpond, Kent, Md.							
24. FUNERAL DIRECTOR NAME <i>Rocket T. Jones</i>			ADDRESS <i>Xkeerly, Del.</i>			25a. DATE REC'D. BY REGISTRAR JAN 2 1980			25b. REGISTRAR'S SIGNATURE <i>Robert Brady</i>							

